

ORAL HEALTH STRATEGY & GENERAL DENTAL SERVICES POLICY – EQUALITY IMPACT ASSESSMENT

DATA AVAILABLE FOR ASSESSMENT OF POLICIES

Introduction

The Equality Scheme, June 2000, highlighted the policies in DHSSPS eligible for Equality Impact Assessment under Section 75 of the Northern Ireland Act 1998. The Oral Health Strategy (OHS) and the General Dental Services Policy (GDS) were identified as being suitable for Equality Impact Assessment. In the provisional timetable for the Department to conduct the assessments, both policies were timetabled for assessment in the first year.

Consideration of available data and research

Information is required to enable DHSSPS to make judgements on any differential impacts of the policies on any of the nine categories listed in Section 75 of the Northern Ireland Act 1998.

The nine categories are:

- different religious belief;
- different political opinion;
- different racial group;
- different age;
- different marital status;
- different sexual orientation;
- men and women generally;
- persons with a disability and persons without;
- persons with dependants and persons without.

Data available relating to dental and oral health services in Northern Ireland

At present there are a number of existing sources of data on dental services and oral health. The next section describes the data items available from each source. It identifies items that will be particularly useful in making a judgement on any differential impacts of the policies on any of the nine categories.

Data Sources

1. Dental Payment Information

This is the payment system maintained by the Central Services Agency (CSA) for all General Dental Practitioner claims. There are approximately 1.2 million claims annually amounting to some 3 million items. This covers the vast majority of all dental work in Northern Ireland. Dentists complete an HS45 form to claim for payment from the CSA for each course of treatment that a patient has. This form is completed for all patient treatments and includes patients who are completely exempt from payment and those who pay for part or all of their treatment (up to a maximum of £354).

The data is processed in monthly batches. Each dataset contains data from every HS45 received and processed by the CSA in a month. The treatment may have been given in any previous month.

It is possible to identify:

- the patient's age;
- the patient's gender;
- the patient's postcode of residence (and therefore ward, district Health Board of residence);
- the patients' payment status and reason for exemption:–
 - patient under 18
 - in receipt of HC2 or HC3 certificate
 - expectant mother
 - nursing mother (12 months from birth)
 - aged 18 in full time education
 - Income support
 - Working Families' Tax Credit
 - Disabled Person's Tax Credit
 - income based / Jobseeker's allowance
- the type of treatment ;
- the dental practice code and postal address;
- the Health Board of Treatment.

In addition, because the patient's postcode and the dentist's postcode are known, it is possible to link data from the 1991 Census of Population to the geographic area (e.g. electoral ward) in which the patient lives and/or the dentist practices.

From the Census data it is possible to establish the social structure of a geographic area in terms of:

- age and gender structure
- religion
- marital status

- household with / without dependants
- residents with long term illness
- Social Class/ economic status.

The CSA have provided Information Analysis Unit (IAU) with a download of a month's data from the dental payment system and will supply IAU with a further 5 months of data in the next few weeks.

2. Central Health Index

The Central Health Index (CHI) contains records of patients registered with a dentist in Northern Ireland and is maintained by the CSA. The Department will be provided with a snapshot of the data in the next few weeks. Data can be obtained from the CHI on:

- age
- gender
- postcode
- dentist cypher number

The marital status of female patients is recorded as 'married' or 'not stated'. It may be possible to use this field in the future but currently it is not sufficiently accurate. In the last five years, the CHI has also held medical exemption information on individuals. This information is used to create free primary care services certificates. This incomplete information can be used to indicate whether someone has a permanent disability. This information may be useful but, as someone who is on income support does not require an exemption certificate to obtain free primary care services, it lacks completeness.

Using this data, it will be possible to analyse the age and gender structure of patients registered with a dental practitioner and to identify the proportion of the population in a ward or at Board level who are registered with a dentist.

The CHI does not contain information on Private Patients who are registered with a dentist. No information is collected by the CSA on these patients. It is also important to note that less than 60% of the population is actually registered with a dentist at any one time. The registration period accepted under GDS is 15 months. As a result, at any point in time the percentage registered can vary. Patients who are not registered can obtain a limited amount of treatment under General Dental Services (GDS), mainly for relief of pain.

The CSA also maintain a record of the history of the mouth of every patient who has had dental treatment under GDS. IAU and the CSA are currently investigating the possibility of extracting any useful information for the purpose of the Equality Impact Assessment from this dataset. This data will be linked to each patient's CHI number and it will therefore be possible to analyse the data by each of the groups as mentioned above. Preliminary views would suggest that this data will not accurately reflect the status of a

person's teeth, for example, private work will not be recorded. However, IAU and the CSA will continue to investigate the data quality.

3. Children's dental health in the United Kingdom 1993

This survey was jointly commissioned by the health departments of each of the four countries of the United Kingdom. The teeth of over 17,000 children aged between five and fifteen years of age were examined (2,095 children in Northern Ireland). The examination was designed to collect information on: the condition of individual teeth and tooth surfaces, trauma to the permanent incisors, assessment of orthodontic and periodontal health, information on erosion of the primary and permanent maxillary incisors and, among twelve year olds, the presence of enamel opacities. In addition, the parents completed a questionnaire regarding their views on dental health and the history of their child with regard to dental visits etc.

The specific aims of the survey were to estimate differences between the four home countries in the dental health of children, to compare results with previous surveys and to provide baseline information on topics not previously measured.

The survey collected data on the following group:

- age

The results were published in 1994, but limited data was published on Northern Ireland. If necessary, it would be possible to obtain the raw dataset from the Essex Archive.

4. Adult dental health survey – Oral Health in the United Kingdom 1998

The survey was based on a representative sample of adults aged 16 and over living in private households in the United Kingdom. All adults living in the selected households were asked to take part in an interview, followed at a later date by a home dental examination for adults with some natural teeth, carried out by a dentist specially trained for the survey. The interview covered dental attitudes, experiences and behaviour. The examination included the existence and condition of natural teeth, the condition of the root surfaces, the nature of contacts between upper and lower teeth, whether there were any spaces between the teeth and if these were filled by dentures or bridges, the type and condition of any dentures and the condition of the gums. The purpose of the survey was to provide information on the current state of adults' teeth and oral health in the four countries of the United Kingdom and to measure changes in oral health since 1988.

The survey collected data on:

- age
- gender
- marital status

A large report was published on the findings, but again the data on Northern Ireland are limited although there is a chapter dedicated to results in Northern Ireland. The chapter contains some data broken down by age or gender. IAU are currently in the process of obtaining the raw dataset to enable ad-hoc analysis of the data.

5. Referral Dental Service data

The CSA pay dentists for any claims they make. The Referral Dental Service in DHSSPS request from the CSA the names of a number of patients from every dentist in Northern Ireland. These patients are called in and examined by a Referral Dental Officer (RDO) to check that work has been carried out by each dentist to a sufficient standard and to check that the work has been carried out as has been claimed for on the HS45 (relates to fraud). Data is collected on the results from these examinations, but they are not broken down by any of the nine equality groups.

6. Community dental services – dental screening

Just over 50% of the population are registered with a general dental practitioner. The Community Dental Service (CDS) provides a safety net for patients who are unable to obtain General Dental Services. They also attempt to screen and identify the most vulnerable patients in:

- Nursery schools, playgroups
- Primary schools
- Secondary schools
- Old peoples homes
- Day centres (Mentally ill, learning disabled)

Consent is needed for children to be screened. It is felt that parents from socially disadvantaged areas do not complete consent forms and therefore some of the most needy children do not avail of this service.

Data are not routinely collected by the CDS in all the above establishments. In the Eastern HSS Board, data are collected on screening in nursery schools and primary schools. The Community Dental Service primarily screens children in a primary school or nursery school who are not registered with a dentist. If they find any problems with a child's teeth, the Service will either try to get the child registered with a dentist or else they will treat the child themselves. In terms of available data, the service lists the primary schools by class in order of % caries free. The Board then concentrates any initiatives on the areas with low % caries free.

Screening data on primary and nursery schools are provided to the Eastern Board annually by Trusts. Data is received by other Boards but it is not in the same format – these data would need to be standardised across all four Boards. Data for 1997/98 were provided to IAU for a one-off exercise on

dental deprivation payments. Dental staff at the Eastern Board will receive data for 1999/00 at the end of September 2000. The data supplied to the Board is not broken down by gender or any of the other 9 equality groups. Age may be estimated because the data is broken down by class. The postcode of the school will enable links to be made with data from the 1991 Census by ward e.g. religion, long term illness, gender.

Information on screening in other establishments e.g. old people's homes is not collected by the Eastern HSS Board. The information on the teeth of primary and nursery school children is seen to be a good reflection of the general state of the teeth of the population in an area.

In the Western HSS Board, the CDS screens all children (registered or not registered) 3 times in their school life. Data on decayed, missing or filled teeth and % caries free may also be collected. The screening of non-school facilities may be more random again.

Each Board does not collect or hold the same data. The data will need to be standardised across all four Boards to ensure that it is meaningful for the purpose of an Equality Impact Assessment.

It may be possible to obtain more screening data from the Trusts, for example breakdowns by gender. This is currently being investigated.

7. Health and Social Well-being survey

This survey was last carried out in 1997 and responses were received from 2,435 households (4,200 people). The next survey will be undertaken in 2001, but at present no request has been made to include any dental questions in the survey. The following questions were asked in the last survey:

1. *May I just check, have you still got some of your natural teeth?*

If answer is YES:

2. *Do you go to the dentist (or orthodontist)?*
for a regular check-up;
an occasional check-up;
or only when you are having trouble with you teeth;
never goes to dentist.
3. *How often do you go to the dentist for a check-up?*
At least once every 6 months
Less often than once every 6 months but at least once a year
Less often than once a year but at least once every 2 years
Less often than once every 2 years

If answer to first question is NO:

When did you last go to a dentist?

*Less than 6 months ago
6 months but less than one year ago
One year but less than 2 years ago
2 years but less than 5 years ago
5 years or longer ago.*

In addition, general information on the respondent is collected on:

- Age
- Gender
- Marital Status
- Long standing illness / disability
- Religion
- Dependants

It would therefore be possible to analyse the answers to the above questions by each of the groups listed above.

8. Aggregate Hospital Data

IAU collect a large amount of data on hospital services.

Regional Information Branch receives quarterly aggregate returns containing information on the following:

- Numbers waiting for an outpatient appointment with a consultant in Orthodontics or Oral Surgery by length of time waiting and Trust.
- Number waiting for an ordinary or day case admission to hospital in Oral Surgery, Restorative Dentistry, Paediatric Dentistry or Dental Medicine Specialty by length of time waiting and Trust.
- Number of outpatient attendances in Oral Surgery or Orthodontics by Trust
- Inpatient activity on Oral Surgery, Restorative Dentistry, Paediatric Dentistry or Dental Medicine Specialty – number of inpatient discharges and day cases by Trust.

Unfortunately, this data is not broken down by any of the nine categories but the data may be useful in providing some information to policy and professional colleagues regarding activity and waiting lists in these specialties to help pinpoint any potential problems in policy

Trusts may be able to provide more detailed information on individual patient records. This may provide data on the nine equality groups.

9. Hospital Inpatients System

Regional Information Branch maintains the Hospital Inpatients System (HIS). The database holds individual records for every inpatient spell in hospital including day cases. The data is held by specialty including Paediatric Dentistry, Oral Surgery and Dental Medicine Specialties.

HIS also contains information on the patient's:

- Age
- Gender
- Marital Status
- Postcode

The Trusts also have the facility on the Patient's Administration System (PAS) to record additional information on:

- Religion – concerns have been raised in the past about data quality
- Race – understand that this is not being recorded.
- Disability – it is not known if this is recorded.

10. British Association for the Study of Community Dentistry Surveys

Northern Ireland has been participating in National Surveys related to dental health since 1994. These surveys are conducted through the British Society for the Study of Community Dentistry (BASCD).

The survey targets 5, 12 and 14 year olds. The 5 year olds are surveyed every other year and in the intervening year 12 or 14 year olds are surveyed. Therefore data for 5 year olds are available for the years 1994, 1996 and 1998; data for 14 year olds are available for 1995 and 1999 and data for 12 year olds are available for 1997.

Information is collected on the average number of decayed, missing or filled teeth, the percentage of children within current dentinal decay and the percentage of children with caries free teeth. The data is available by HSS Board but is not broken down by gender or any of the other equality groups. It may be possible to identify the gender of the 5 year olds because of the school they were attending ('all boys' or 'all girls'), but it would not be possible to identify the gender of the 12 or 14 year olds in this manner. It would be feasible to collect the data by gender in the future.

There is a fear that the need for parental consent may result in some of the more needy children being excluded from this survey and this may effect the accuracy of any results.

11. Additional information collected in the Western HSS Board

In 1992, a self assessment questionnaire involving 1,500 people was carried out. This exercise is just about to be repeated. The only equality group covered is age and postcode is also collected.

In 1995, a knowledge and attitude questionnaire using unregistered patients in the Board area (about 300) was carried out by Ulster Marketing Surveys. No data on any of the equality groups was collected.

12. Additional information collected in the Northern HSS Board

Two surveys have recently been carried out in the Northern HSS Board:

- (i) The 'Oral Health Survey of Northern Health and Social Services Board Residents aged 65 years and over' was carried out in 1999. The survey contains data on age and gender. Information was collected on the health of patients' teeth and behaviours and attitudes with regard to attending dentists.
- (ii) A survey of Dental services provided to people with a learning disability was carried out in the NHSSB area in 1999. Information was collected from General Dental Practitioners and Muckamore Abbey Dental Department. Data is collected on age group. The results from this survey are still in draft form.

Information gaps

At present, no data is collected on sexual orientation or ethnic origin. In addition, the only source of data on religion or dependants is the Health and Social Well Being Survey, apart from the link to the 1991 Census of Population data if postcode is present in the dataset.

Summary

It is evident that there is a large amount of data available relating to general dental services and oral health. However there are a number of gaps as highlighted in the paragraph above. In addition, none of these data have been analysed in relation to specific Departmental or Board policies. Once these policies have been clearly defined then work can begin on analysing the information to establish whether there is any differential impact on any of the 9 groups.

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